Welcome to the West Virginia Workers' Compensation Webinar!

Changes to Title 85 Rules Effective August 2008

July 11, 2008

West Virginia
OFFICES OF THE
INSURANCE
COMMISSIONER

Title 85, Series 1 (Rule 1)

Rule 1 addresses:

- Claims Management and Administration
- Primary rule for non-medical claims issues
- Includes crucial time standards

Rule 1
Self-insured Employers

Claims handling standards for self-insured employers were previously located in Rule 18. These standards, which in many instances differed from the standards applicable to private carriers, were removed from Rule 18, and the uniform standards set forth in Rule 1 were made applicable to both private carriers and self-insured employers.

Rule 1
Definitions of “Receipt” and “Filed”

85-1-2.

- “Filed” as used in rule means:
  - If mailed, date postmarked
  - If faxed, date sent
  - If emailed, date marked sent
  - If hand delivered, date delivered
- “Receipt” as used in rule means:
  - If mailed or hand delivered, date document is in possession
  - If emailed, date document is placed in inbox
  - If faxed, date document is received in fax machine
- Generally, “Filed” applies to duties of claimant, “received” applies to duties of adjuster

Rule 1
Claimant's Report of Injury

Subsection 3.1.

- Clarification made that claimant's failure to report injury within 2 working days cannot be sole reason to deny compensability
- Lack of timely report of injury (within 2 working days) by claimant can be *one factor* weighing against compensability
- There must be another substantial reason to deny compensability

Rule 1
Claimant Underpayments

Subsection 3.2.

- Old version: underpayments dating back up to two years
- New version: Two-year limit on underpayments eliminated
- Per W. Va. Code § 23-4-1c(d), the rate of benefits “shall be adjusted both retroactively and prospectively upon receipt of proper wage information”

Rule 1
Claimant Retirement

Subsection 5.2.

The substantive change to this section clarified that, if an individual retires, as long as that individual remains retired, he or she is disqualified from receiving TTD benefits arising from any compensable injury received from the place of employment from which he or she retired, unless the application for TTD benefits was received prior to his or her retirement

Rule 1
Claimant Retirement

Subsection 5.3.

Under the new version of this section:

> If a period of disability includes a reasonably ascertainable period of time during which the injured worker would not have been performing work for any employer, then temporary total disability indemnity benefits shall not be paid during that period.

Rule 1
Notice and Litigation

Section 7

- New provision in Rule 1
- Reflects changes by Legislature in 2008

Rule 1
Notice and Litigation (Con't)

Subsection 7.1.

- Clarifies that in all WC claims, the only parties to the claim are the claimant (or, where applicable, the claimant's dependents) and the employer
- For claims against state-administered funds, the OIC is also a party to the claim

Rule 1
Notice and Litigation (Con't)

Subsection 7.2.

"Upon the making of any decision, the responsible party shall send the parties a written notice of the decision setting forth the decision and the basis thereof, and informing the claimant or claimant's dependants of the right to protest the decision by filing a protest with the Office of Judges within sixty (60) days of the receipt of the decision"

Rule 1
Notice and Litigation (Con't)

Subsection 7.3.

- The insurance carrier has sole authority to act in the place of an insured employer
- An insured employer may only protest decisions of the insurer under two circumstances:
  - Decisions involving OP Board findings; and
  - Decisions awarding PPD percentage award based on treating physician findings
- Because the insurer has sole authority to act on behalf of the employer, the insurer must agree that a protest should be filed

Rule 1
Non-Awarded Partial Benefits

Subsection 9.2.

- NAP benefits are barred when a claimant has previously received a PPD award, and the claim has not been reopened for PPD
- If claim is re-opened for PPD or PTD benefits, NAP benefits may be payable

Rule 1
Time Standards

Subsection 10.2.

- The time frame for making non-medical decision in OP claims has been extended from 15 working days to 90 days
- Also, the new rule limits the time that this deadline may be tooled for the gathering of additional evidence to 30 days

Rule 1
Time Standards (Con't)

Subdivision 10.4.a.

This section of the Rule was amended to allow for a deferral of the 120-day evaluation required by W. Va. Code § 23-4-7a if the period of expected disability exceeds 120 days.

Rule 1
Time Standards (Con't)

Subdivision 10.5.a.

- Time frame for acting upon PPD evaluation reports from physicians
- This time frame was changed from 30 days to 30 working days

Rule 1
Time Standards (Con't)

Subdivision 10.5.b.

- Time frame for referring a claimant for an IME following a claimant's request for a PPD evaluation
- This section is new to Rule 1, and was imported from Rule 18
- Time frame is 30 working days from the date the request was received

Rule 1
Time Standards (Con't)

Subdivision 10.5.c.

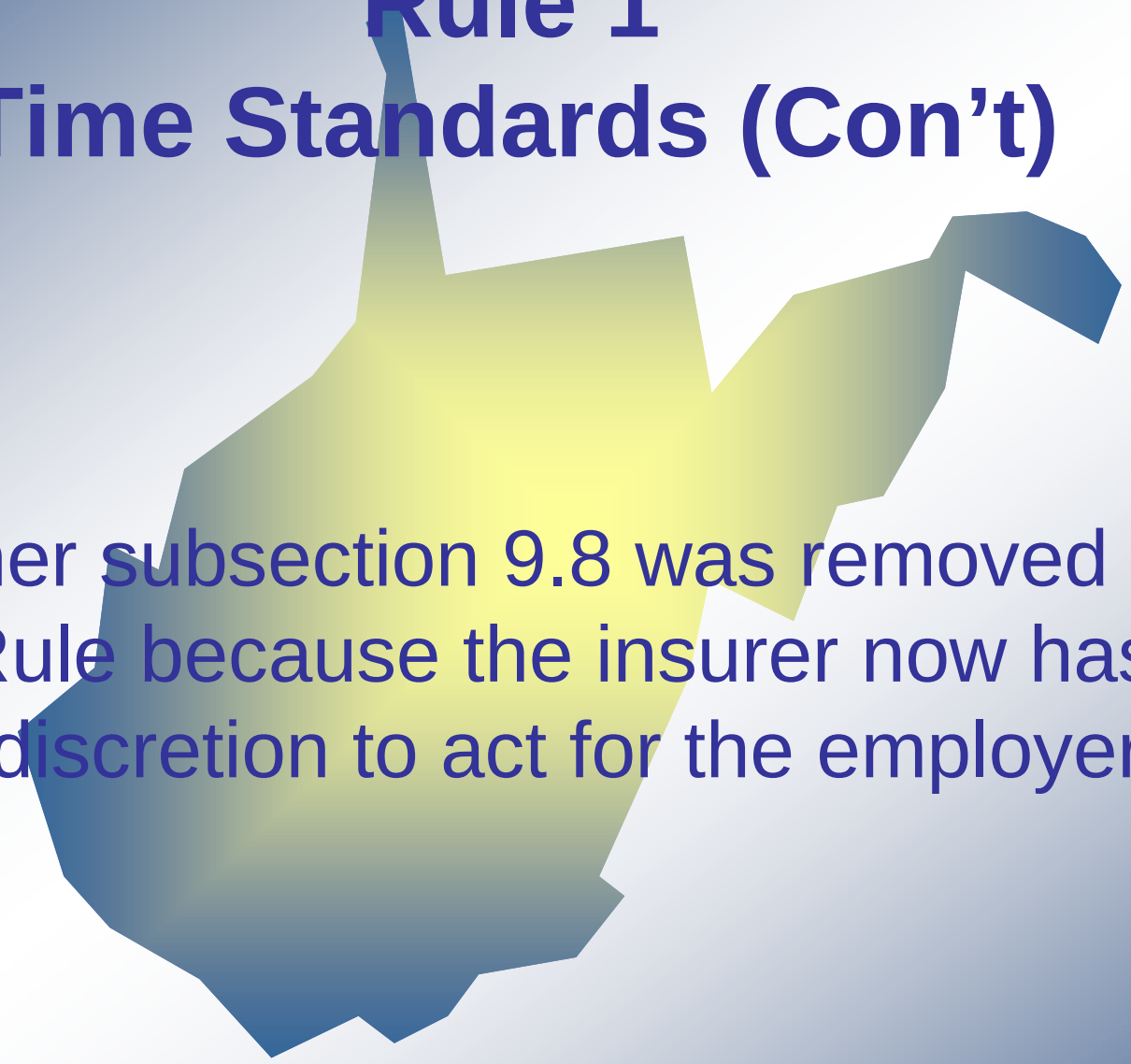
This provision of the Rule (which was moved from the old Section 6.3) allows for the payment of PPD awards either by lump sum or in installments. Previously, the Rule only provided for installment payments

Rule 1
Time Standards (Con't)

Subdivision 10.6.a.

- Time frame for ruling upon application for re-opening claim
- This time frame was changed from 10 working days to 30 working days

Rule 1
Time Standards (Con't)



Former subsection 9.8 was removed from the Rule because the insurer now has the sole discretion to act for the employer

Rule 1
Time Standards (Con't)

New subsection 10.7.

- Time frame for compliance with all orders
- New provision requires compliance with orders issued by the OOJ, BOR or WVSCA within 30 days of receipt by the carrier. The former rule counted the 30-day period from the date that the order was entered

Rule 1
Overpayments

Subsections 12.2. and 12.3.

- Limits the recovery of overpayments to those claims pending with the same insurer
- Amended to prevent the recovery of overpayments from dependent benefits and 104 week (fatal) benefits
- Limited the recovery of overpayments; overpayments may only be recovered from TTD, PPD, PTD, NAP, temporary total rehabilitation benefits, temporary partial rehabilitation benefits, and travel reimbursement benefits.

Rule 1
OP and OD claims

Subsection 13.1.

- Comprehensive amendment
- Old version: Required lung diseases other than OP resulting from the inhalation of minute particles of dust to be filed as OP claims
- New version:
  - Eliminated the requirement that all lung diseases other than OP resulting from the inhalation of minute particles of dust be filed as OP claims. These claims may now be filed as either OD or OP claims, at the discretion of the claimant
  - However, if a claimant files the claim as an OD, the claim must be referred to the OP board for a determination of the claimant's whole body medical impairment

Rule 1
Closure of claims

The former section 13 has been stricken. This section provided for the "administrative closure" of a claim if the claimant had not received any benefits for 6 months. The rule required that the claimant be sent notice of the closure, and be provided with the opportunity to protest the decision with the OOJ.

Pursuant to a recent decision by the WVSCA, an insurer may internally "de-activate" a claim consistent with its internal business practices, but a claimant should not be provided with any notice of such action, and any internal designation of a file's status may not in any way affect the claimant's substantive right to benefits in the claim

Rule 1
Responses to Complaints

New section 16

- Requires that an insurance carrier or self-insured employer respond to any inquiry from the OIC regarding any consumer complaint, within 15 working days of the date of the inquiry
- Requires a complete written response addressing all issues raised by the complainant or the OIC

Title 85, Series 2 (Rule 2)

Rule 2 addresses the Workers' Compensation Claims Index

- Sets forth policies and procedures for the claims index
- The claims index is a database which carriers can use to access basic information about any prior WC claims of a claimant
- Includes EDI reporting requirements for carriers and self-insureds

Rule 2 Changes

- Changes in various sections to clarify that state-administered funds must report to EDI.
- Subdivision 4.2.g. was amended to add PPD percentage as a claims index field
- Subsection 5.1. was amended to permit a private carrier or self-insured employer's agent or attorney to access the claims index

Title 85, Series 6 (Rule 6)

Rule 6 addresses:

Workers' Compensation Debt Reduction Fund Assessments and Regulatory Surcharges

Rule 6 Changes

- Subsection 3.10. was amended to provide further clarification of the types of premiums subject to assessment
- Subsection 4.1. was amended to set forth the statutory surcharge percentages in effect until 2013 per H.B. 4636
- Various sections amended to provide 90 days notice if percentage amount changes (was 60 days).

Title 85, Series 8

Rule 8 addresses:

Workers' Compensation Policies, Coverage Issues and Related Topics

- All revisions to this Rule involved Section 9 of the Rule, relating to time frames for providing notice to the insured and to the OIC when WC policies are terminated
- Changes follow changes to the law made by H.B. 4636

Title 85, Series 18 (Rule 18)

Rule 18 addresses:

- Self-insurance, self-administration and third-party administrators

Rule 18
Significant Changes

- Throughout rule, claims handling standards were stricken in deference to Rule 1, which now applies to carriers and SI's
- Former provision in Section 7, pertaining to catastrophic occurrence coverage, amended to make requirement discretionary (based on changes in law in 2007)

Rule 18
Significant Changes

Claims handling standards for self-insured employers were previously located in Rule 18. These standards, which in many instances differed from the standards applicable to private carriers, were removed from Rule 18, and the uniform standards set forth in Rule 1 were made applicable to both private carriers and self-insured employers.

Rule 18
Significant Changes

A former provision in Section 7 pertaining to catastrophic occurrence coverage has been amended to make this requirement discretionary (based on changes in law enacted in 2007)

Rule 18
Significant Changes (Con't)

- Requirement in Subsection 8.3. of SIE's maintaining a minimum security amount of $1 million stricken
- Section 9., which requires that the SIE notify the OIC of any significant changes in the structure or status of the SIE, was amended to require that the SIE file all relevant documents regarding these changes with the OIC, and to provide the OIC broader discretion with regard to the continuing self-insured status of the SIE following such changes

Rule 18
Significant Changes (Con't)

- Subsection 10.1. was amended to prohibit SIE's from transferring their accrued WC liabilities to the State if they terminate their self-insured status
- Penalty provision in Subsection 13.9. for compliance violations was amended from $5000 "per review" to $500 "per occurrence"

Rule 18
Significant Changes (Con't)

- Subsection 13.9. was amended to permit the OIC to place a non-compliant SIE into a corrective action plan
- Subsection 14.4. was amended to provide the OIC with the authority to audit an SIE at any time
- Section 17. was amended to require that a TPA handling WC claims be licensed by the OIC (pursuant to new law in H.B. 4636)

CONTACT INFORMATION

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